

# BoardRoom Press

*A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards*

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## Building Strength Through Innovative Partnerships

Human Understanding:  
Digging Deeper with the Board

Compassion in Action:  
A Population Health Approach  
to Palliative Care

### SPECIAL SECTION

Guidelines for Effective  
Board Executive Sessions

### ADVISORS' CORNER

Five Steps to Improve  
Board Effectiveness:  
Now Is the Time to Act



## What Is Your Why?

One of the lessons healthcare board members are learning in light of COVID is the vital connection between workforce well-being and quality of patient care. A workforce that is well cared for can do an infinitely better job providing person-centered care. But now our workforce is in crisis. Where does the board come in?

We know that governance effectiveness starts with self-awareness. Awareness of the organization's performance, and awareness of the board's performance. But what about awareness of the "why?" Why do your leaders serve? Why does your staff serve? Why do your board members serve? What kind of legacy do they want to leave at the culmination of their tenure? If you know the answers to these questions, what can you do with that information to help your organization—and the people at the heart of it—fulfill their "why?"

This issue of *BoardRoom Press* gets back to the "why"—the human side of things, with articles that dive into meaningful partnerships and community connections, applying human understanding principles to every aspect of what we do, and then enabling these initiatives through governance effectiveness principles, from best practices for executive sessions to building self-awareness from the board on down.

*Kathryn C. Peisert*

Kathryn C. Peisert,  
Managing Editor

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# Building Strength Through Innovative Partnerships

By Chris Cullom, FACHE, Mercy Fitzgerald Hospital, Trinity Health Mid-Atlantic

The healthcare industry has long been in a state of constant change. Technological advancements, treatment breakthroughs, changes to regulations, and updates to best practices are just a few of the reasons why successful industry leaders and boards have never been afforded the luxury of rest in their race to stay ahead of the curve. The COVID-19 pandemic kicked things into an even higher gear when, seemingly overnight, hospitals and healthcare providers were forced to rethink virtually every aspect of their business model, while maintaining a watchful eye on the bottom line.

To overcome challenges brought on by industry transformations, many health systems have leveraged mergers and acquisitions to expand market space, strengthen bargaining positions, and streamline supply chains to attain more secure footing. The value of M&A strategies became increasingly apparent as smaller hospitals and systems fell to the operational stress and financial burden brought on by COVID-19. But while M&A can be an effective path to organizational growth and sustainability, innovative partnerships can lead to as much or even more success, strengthening an organization while also addressing the needs of its community.

From access to affordable care, healthy foods, and sufficient housing, a myriad of socioeconomic factors collectively and exponentially affect many Americans' ability to live their healthiest life. The fact that our nation's health insurance system can be hard to access for many individuals only compounds the issue, forcing many to prioritize living essentials over critically needed care. In cases of preventive and chronic medical conditions, short-term payoffs from delayed care only prolong and worsen long-term health consequences.

As a mission-based organization, Mercy Fitzgerald Hospital has always been committed to supporting and giving back to its community members, especially in the areas of their greatest need. Since the beginning of my tenure as President, our board and senior leadership team have been focused on addressing the



**Chris Cullom, FACHE**  
President  
Mercy Fitzgerald Hospital,  
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challenges responsible for health inequities in the communities we serve. We have received wide-ranging, community-focused support from the Trinity Health corporate system office in these endeavors, as well. Trinity Health is particularly supportive of initiatives designed to combat racial injustice, which plays an outsized role

in the social determinants of health. From hosting internal educational Webinars to publicly declaring racism as a national health crisis, our national Diversity and Inclusion office has led efforts to inspire and empower all Trinity Health colleagues to better act as health advocates on behalf of our neighbors.

I believe that better health outcomes can be achieved by taking a holistic approach to community wellness, through the formation of meaningful partnerships designed to resolve root causes of public health challenges. Many broad challenges are too big to tackle alone, and I am proud of the partnerships Mercy Fitzgerald has established—guided by our board—to properly address the needs of our community, and in turn blunt the impact of the forces driving health inequity. As a community hospital board, our members are focused on serving as the voice of our neighbors, connecting us with community partners, representing our organization at local events, and supporting the advancement of our mission: to serve together as a compassionate and transforming healing presence within our communities. These partnerships span the spectrum of our operational footprint, involving a range of internal departments, including Business Development, Government Relations, and Community Health and Well-Being.

## Business Partnerships

Mercy Fitzgerald Hospital has a long-standing partnership with Marquis Health Services, an administrative and consulting healthcare firm for skilled nursing facilities, to provide services that are not available within our hospital but have been identified as a critical need within our community. Our latest endeavor

## Key Board Takeaways

Following are steps that healthcare boards and leaders can take to form meaningful partnerships designed to resolve root causes of public health challenges:

- Ask board members to leverage their areas of expertise and contacts within the community to establish partnerships.
- Identify business partnerships that can supplement or provide critical services that are not available within your hospital or health system.
- Work with government partners to identify gaps in public health services and ways in which your organization can help to bridge those.
- Collaborate with likeminded non-profit organizations to support underserved communities in your region.
- Partner directly with community members to strengthen the bond between your organization and the people it serves.

together is the construction of a new Transitional Care Unit, which will support the growth of our organization while meeting the needs of our community.

## Government Partnerships

Up until recently, Delaware County, Pennsylvania, where Mercy Fitzgerald is located, did not have a health department. Throughout the COVID-19 pandemic, Mercy Fitzgerald stepped up to meet the need for public health services, leading efforts like community COVID-19 testing and vaccinations. Since March 2020, Mercy Fitzgerald has administered over 48,000 COVID-19 tests to members of our community. Since the COVID-19 vaccines became available, we have vaccinated more than 15,200 people in our community. Now, with the Delaware County Health Department recently established, we have transitioned into a new phase of our partnership, marked by the presentation of \$75,000 in grant funds for continued community vaccination efforts, with a focus on homebound, immigrant, and homeless populations.

We have also partnered with state and federal agencies on community health response initiatives. Like earlier this year, when the omicron variant led to surging COVID-19 case numbers and emergency departments were pushed to their limit, Mercy Fitzgerald worked with Delaware County officials to quickly establish a free community COVID-19

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# Human Understanding: Digging Deeper with the Board

**T**he Governance Institute spoke with Susan Edgman-Levitan, PA, Executive Director of the John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital, Co-Chair of the Mass General Brigham Patient Experience Leaders Committee, and Lecturer in Medicine at Harvard Medical School, to discuss how her organization has applied Human Understanding to their work. Prior to this role, Ms. Edgman-Levitan was the founding President of the Picker Institute. She is also a Senior Fellow at IHI and a member of the IHI Lucian Leape Institute. She has been a principal investigator on the AHRQ-funded Consumer Assessments of Healthcare Providers and Systems Consortium since 1995. Below are the highlights of our conversation.



**The Governance Institute (TGI): Looking back at your work with the Picker Institute, how has the idea of patient-centered care expanded at our nation's healthcare organizations today?**

*Susan Edgman-Levitan (SEL):* That work has expanded a great deal. The concept of patient- and family-centered care has evolved into *person*-centered care, which connects with the Human Understanding work at NRC Health: how we understand and help to improve all of the issues that impact someone's ability to manage and improve their care.

For us, the concept has expanded in four primary ways:

1. We are focusing on a deeper understanding of social determinants of health (SDOHs) and how we can support not just the patients we serve but also the communities where they live.
2. We are working to change the clinical paradigm from "what is the matter with you?" to "what matters to you?" We want to understand where we have common ground to support our patients' efforts to manage their chronic conditions. We also want to signal that "what matters to you matters to us" as we strengthen the trust our patients and communities have in us.
3. We are working to better understand what matters to our staff, which is even more critical since COVID. If we aren't taking care of our staff, they can't take care of the patients we serve. This includes hiring the right people, orienting them to the values of our organization, and how we hold them accountable to those values. It's about understanding the "why" for our staff—why do they choose to work in healthcare and in

**||** One of the things I'm most excited about is that we are now starting to implement NRC Health's Human Understanding Program, taking a programmatic approach to focus on what matters to patients before, during, after, and outside of care."

—Susan Edgman-Levitan

the Mass General Brigham (MGB) system. We also know that helping people connect with the passion and commitment that motivated them to make a difference in healthcare is critical to reducing burnout. Our research has shown that the singular commonality of high-performing patient- and family-centered organizations is being a great place to work. That is critical for leaders to galvanize behind.

4. We have launched a multi-million-dollar effort, United Against Racism, to address the impact that racism has on MGB patients, employees, and the broader community. We believe that systemic racism is a public health issue. This effort includes initiatives to increase the diversity of our boards, leadership, clinicians, and staff. We are also focusing on policies and workstreams to address the structural racism that results in inequitable care. This includes translating our patient portal into eight different languages, increased access to interpreters, enhanced access for all patients, and improving our community health outcomes.

**TGI: How would you describe the ways Human Understanding is different from typical patient experience activities such as CAHPS surveys?**

*SEL:* It gets at the culture of the organization and how that impacts the way we are delivering care to our patients. It connects the "why" for our staff with how we partner with patients to understand their needs. From there, we learn at a much deeper level the interventions and strategies that make sense to the patients, and that is where we focus our implementation.

Patient experience surveys are excellent at revealing problems, but they don't tell us the solution. We have patient advisory councils that focus on how patients define the problems and what solutions they would propose. For boards and leadership—this process saves so much money. If you leave us to our own devices to design an intervention to address a problem, it is usually too complicated, too difficult, too expensive, and likely to be wrong. Patients tell us exactly what they need, and they will often tell us that two-thirds of our solution doesn't matter to them.

To do this, we use a human-centered design process that many organizations are adopting. We bring together doctors, nurses, practice managers, other care team members, and patients to define the problem and potential solutions, from everyone's perspectives. It is most important to define the problem accurately. Then we whittle the solutions down, vet them again from the same multi-disciplinary perspective, and then test and implement. We have found this to be incredibly effective.

**TGI: How can we make a more direct connection between patient experience, Human Understanding, and quality outcomes?**

**SEL:** Healthcare leaders and board members are often confused about what we mean by patient experience. They sometimes still think it's about the food and parking. We design the CAHPS surveys to query people about the aspects of care that are essential to high-quality care, *through the eyes of the patient*. They focus on the aspects of care that contribute to better outcomes: communication about their diagnosis and medications, coordination with their care team, access to care when they need it, and getting the information they need to manage their own conditions. From this perspective, it makes sense that patient experience scores are directly related to outcomes. This perspective is also the fundamental underpinning of the Human Understanding approach that NRC Health is driving.

My CAHPS colleagues conducted a study with the VA on patients admitted for a heart attack.<sup>1</sup> They looked at the technical quality of care as well as patient experience data from their hospitalization through follow-up ambulatory care. They measured symptoms, mental health, patient experiences, and overall outcome measures. The only predictor of how well a patient would be doing one year post-discharge was the patient experience scores. More research continues to link clinical quality, staff engagement, and outcomes with patient experience results.

NRC Health also makes it easy to review patient experience data by race and ethnicity. If these data are not easily accessible, it is difficult to achieve overall quality targets—many of which are tied to reimbursement. The largest disparities exist for our Black and LatinX patients. Because we stratify the data, we can see where the problems are and then develop targeted interventions to address those patients' needs. Designing culturally sensitive and affirming interventions is also where partnering with patients to help design care becomes even more critical.

**TGI: Board members at acute-care hospitals are facing the challenge of how to get away from a hospital-centric structure and make more impact in the outpatient setting. Can you give some examples of how to apply Human Understanding in the inpatient vs. outpatient setting?**

**SEL:** In the inpatient setting, surgical services have always done better than medical services. They have well-defined teams and workflows; they know what their role is; there are well-defined algorithms for what is supposed to happen each day. Patients and families are often prepared for what will happen in the hospital before they arrive. They know what to expect, what equipment they will need, how long the stay will be, and what their home care will entail. Medical patients are very different—usually older and sicker, with unpredictable lengths of stay. In many organizations, they are cared for by a hospitalist who doesn't know them. To foster more coordinated care and trust, our primary care doctors make social calls to their patients in the hospital, so the patient knows that their doctor is informed and consulted. We are also educating patients about the role of the hospitalist, why they are an expert in inpatient care, why that is important, and how that person is communicating with their ambulatory doctors. Just providing this information to patients has helped increase HCAHPS scores. Many of our hospitalists hand out business cards with their cell phone number on them. We also ask family members to bring photographs or other things about the patient to give the care team a sense of who the patient is and what matters to them. Finally, we have our hospitalists shadow primary care doctors, so they have a better understanding of the primary care doctors' role and relationships with their patients.

In the primary care setting, we are working to understand how to better engage patients. We have a set of engagement questions about the most important things to them, and usually it is medication, diet, and exercise. Doctors don't talk about these things very much, but they are critical to chronic disease management. Doctors who do a better job of this get higher overall ratings from their patients.

Primary care providers need training support. We are also working to understand how different problems or conditions can be addressed by different visit types. When is a telehealth visit sufficient versus when must a patient be seen in person? We are also working to create better teamwork and support to address the needs of our clinical staff. When is a pharmacist important? How can community health workers support patient engagement and chronic disease management or substance use recovery?

**TGI: What are the most important things the board and leadership should be doing (or not doing) to help the organization implement Human Understanding?**

**SEL:** Having patients on the board is critical—people who can bring the patient lens to the discussions. We have patients, family members, and parents on our boards and several committees. They bring invaluable perspectives that often change our approach. Lay board members who are community leaders do not always represent these perspectives, so it is important to identify people who are committed to providing the views of patients.

Second, boards need to see patient experience and safety data regularly, with an engaged quality/safety committee that can dig deeper. Safety and experience often go hand in hand. Boards need to be educated about how to interpret the data so they understand what they are looking at and what questions are important. Organizations that take this seriously start every board meeting with both a positive and negative patient story, to illustrate their positive impact as well as their challenges. It sends a message that patients really are at the core of what we do and why we are here.

**TGI: How are you applying Human Understanding to efforts around SDOHs?**

**SEL:** In 2008, Massachusetts passed universal coverage (health insurance) legislation, which also required that every hospital create patient and family advisory councils. I wish every state did  
*continued on page 13*

1 Mark Meterko, et al., "Mortality among Patients with Acute Myocardial Infarction: The Influences of Patient-Centered Care and Evidence-Based Medicine," Health Services Research, October 2010.

# Compassion in Action: A Population Health Approach to Palliative Care

By Steven Pantilat, M.D., University of California, San Francisco

**T**he good news is that we are living longer than ever. The average lifespan in the U.S. is 80 years compared to just 50 in the year 1900. In 2010, there were 5.5 million Americans over age 85. By 2050, that number is expected to nearly quadruple to 19 million.<sup>1</sup> The bad news is that despite these gains in longevity, the death rate hasn't budged—it remains stuck at 100 percent. Yet within this sobering statistic lurks another stark reality. While we are likely to live longer, we are also likely to spend part of that time, years or decades, with a serious illness like cancer, Parkinson's disease, or heart failure. In fact, two-thirds of Americans over age 65 have a serious illness. Unfortunately, in the current healthcare system, people with serious illness often receive care they do not want and from which they will not benefit (e.g., ICU care for someone dying of leukemia) and fail to receive care they do want from which they will benefit (e.g., good pain control for someone with pancreatic cancer). The last months of life are too often characterized by repeated hospitalizations, high healthcare utilization, and poor quality of care.<sup>2</sup> The results are unnecessary suffering and stress for patients and their loved ones. As healthcare leaders, we can and must do better. Palliative care offers an effective, proven approach to do just that.

## Benefits Reach beyond End-of-Life Care

Put simply, palliative care is medical care focused on improving quality of life for people with serious illness. Misperceptions persist among patients and healthcare professionals that palliative care is just for end of life. While palliative care teams certainly have expertise in easing suffering at the end of life, palliative care also provides many benefits for people with

cancer, heart failure, and Parkinson's disease, among others, throughout the course of illness. By providing expert symptom management, communication about treatment preferences and goals, and psycho-social-spiritual support, palliative care teams do everything good we want for patients—relieve pain and shortness of breath, improve quality of life, increase satisfaction with care, and reduce unnecessary healthcare utilization.<sup>3</sup> In some studies patients receiving palliative care even live longer. By applying a population-based approach to palliative care for people with serious illness, healthcare leaders can ensure these benefits for their patients, families, and institutions. It is easiest to implement a population-based approach to palliative care by setting (inpatient, outpatient, home) and to target the limited resource of specialty palliative care to the neediest patients.

## A Population-Based Approach to Palliative Care

Most people with serious illness will spend time in the hospital for treatments, management of complications due to those treatments, and exacerbations of illness. As with many healthcare services, the current approach to palliative care in the inpatient setting is reactive—palliative care teams see the patients they are asked to see. Unfortunately, this approach leaves out many patients with significant palliative care needs and allows for unconscious bias in referrals.

A novel, proactive, population-based approach is to use the electronic medical record (EMR) to find patients who would benefit from specialty palliative care.<sup>4</sup> At the University of California, San

## Key Board Takeaways

Boards play a key role in defining the vision and strategy for the organization. Asking a few key questions and advocating for a larger role for palliative care services can help board members promote high-quality care for the most seriously ill patients:

- What palliative care services do we offer? In which settings and for which patients?
- How do we know that patients who can benefit from palliative care or are in need of such care are receiving it when and where they need it?
- What palliative care quality measures do our palliative care teams monitor and what is our performance compared to similar organizations?
- Where are there opportunities to engage our palliative care services in other important initiative and strategic goals like access and value?
- How can we integrate palliative care with our population health strategy?
- How can a population health approach involving palliative care help us achieve better health equity?

Francisco (UCSF), we have been piloting such an approach. We developed an algorithm to identify inpatients with serious illness as a first step to finding those with palliative care needs where we:

- Designated some services, such as malignant hematology and advanced heart failure, as "serious illness teams" and assumed all their patients have some palliative care needs.
- Indicated that patients in the ICU for more than 48 hours are likely to have palliative care needs.
- Adapted a list of "serious illness" ICD-10 codes<sup>5</sup> to identify patients not captured with the first two criteria and added a search in the EMR for the word "metastatic" because we found in chart review that many people with

*continued on page 14*

1 AARP, "The Next Four Decades 2010–2050," May 2010.

2 Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, Washington, DC: The National Academies Press, 2015.

3 Marie Bakitas, et al., "Effects of a Palliative Care Intervention on Clinical Outcomes in Patients with Advanced Cancer," *JAMA*, August 19, 2009; Jennifer Temel, et al., "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *New England Journal of Medicine*, August 19, 2010; Joseph Rogers, et al., "The Palliative Care in Heart Failure (PAL-HF) Randomized, Controlled Clinical Trial," *Journal of the American College of Cardiology*, July 18, 2017; Steven Pantilat, et al., "Comparison of Integrated Outpatient Palliative Care With Standard Care in Patients With Parkinson Disease and Related Disorders," *JAMA Neurology*, May 1, 2020.

4 Robert Wachter, Timothy Judson, and Michelle Mourad, "Reimagining Specialty Consultation in the Digital Age: The Potential Role of Targeted Automatic Electronic Consultations," *JAMA*, August 6, 2019.

5 Amy Kelley, et al., "Identifying Older Adults with Serious Illness: Transitioning from ICD-9 to ICD-10," *Journal of Pain and Symptom Management*, June 2019.

# Guidelines for Effective Board Executive Sessions

By Larry Gage, Esq., Alston & Bird LLP and Alvarez & Marsal, and Lawrence Prybil, Ph.D., LFACHE, University of Kentucky College of Public Health

**T**he effective use of executive sessions by non-profit health-care governing boards appears to be overdue for attention.

Compared with other governance practices, relatively little has been written about the use of executive sessions by non-profit governing boards. While some assessments do exist, most are either written about non-profit corporations generally or from the perspective of specific kinds

of non-profits, such as trade associations or educational institutions. By contrast, little or nothing has been written about the use of executive sessions by non-profit hospital and health system boards.

A 2014 literature search framed largely from the perspective of trade associations found that "an exhaustive search yielded one white paper on the

role that executive sessions play in non-profit organizations."<sup>1</sup> That white paper was first published in 2007 by the non-profit organization BoardSource. According to the authors of the 2014 survey, it was based on "the opinions of an attorney, a non-profit CEO, and a non-profit consultant" rather than on scholarly research.<sup>2</sup> As a result, the authors of the 2014 literature search concluded that "Within the literature there is no common understanding of who attends executive sessions, when and for what purposes they should be convened, how they should be documented and reported, or the impact executive sessions have on organizational effectiveness."<sup>3</sup>

The goal of this article is not to conduct a definitive scholarly analysis of executive sessions. Rather it is an attempt to begin to fill the gap in the current literature with respect to their use by non-profit hospital and health

system boards. It draws on the limited available resources about other kinds of non-profits and our own experiences to focus on whether and how non-profit hospital and health system boards can make effective use of executive sessions.

## The Purpose and Reasons for Board Executive Sessions

The use of executive sessions is widely misunderstood and continues to be debated even by governance experts. As a result, it is a practice that can be subject to misuse, which can cause mistrust and bad feelings among board members, and between boards and management. However, there can be helpful and appropriate uses of executive sessions by hospital and health system boards that build (rather than break down) trust and enhance effective leadership.

BoardSource describes executive sessions as "a special meeting-within-a-meeting that provides an opportunity for the board to meet privately to handle sensitive and confidential issues, foster robust discourse, and strengthen trust and communication. They are usually exclusive to board members, but others, such as the chief executive, may be invited to join for all or part of a session."<sup>4</sup>

Executive sessions can serve several core purposes. These sessions:

- Assure candor and confidentiality for board members in discussing sensitive matters.
- Create a mechanism for board independence and oversight.
- Provide an opportunity for all board members, not just a select few, to participate in governance.
- Can enhance relationships among board members and with the chief executive and professional advisors.

## Key Board Takeaways

- Include an explicit policy statement regarding the use of executive sessions in your bylaws or board charter.
- Regularly schedule executive sessions as part of every board meeting.
- Except in extraordinary/emergency/crisis situations, never call executive sessions on the spur of the moment.
- Have an agenda with specific issues to be discussed at the executive session, and limit discussions to those issues.
- If the executive session includes a period in which board members may be invited to raise new concerns or suggest agenda items for future board meetings, reserve substantive discussion of any such new issues or items for future meetings.
- Conduct some portion of each executive session with the presence of the CEO (and possibly other staff, such as the general counsel, chief compliance officer, or chief medical officer, if needed to discuss specific issues).
- For executive sessions without the CEO, share the topics discussed with the CEO immediately following the session, and include actions that need to be taken by CEO and staff in the report.
- Keep a written record of each executive session, preferably by the board chair or governance support staff. This should be separate from board meeting minutes and kept in a secure place. Such written records should be summaries rather than detailed minutes, except to the extent that certain kinds of discussion and/or decisions are subject to legal requirements (e.g., conflicts of interest, discipline of board member or senior staff, etc.).
- For public hospital boards, the ability to hold an executive session that is not open to the public, and the topics that may be discussed in such sessions, are likely to be governed by state open meeting and open records laws.

Most governance experts who support the use of executive sessions agree that they can also be useful for several more specific reasons, including to:

- Preserve confidentiality when discussing sensitive topics (e.g., audit, legal matters, and personnel issues).
- Permit board members to engage in candid and open conversations

1 Mark Engle and Anne Cordes, "Executive Sessions in Nonprofit Organizations: A Review of Current Literature," 2014.

2 BoardSource Resources: Outi Flynn, *Meeting, and Exceeding Expectations: A Guide to Successful Nonprofit Board Meetings*, 2009, and *Executive Sessions: How to Use Them Regularly and Wisely*, 2007.

3 Engle and Cordes, 2014.

4 BoardSource, 2007 and 2009.

and to consider a range of options in considering certain confidential matters.

- Allow board members to frankly and honestly assess their own performance and that of the board as a whole.
- Permit the board to raise and discuss sensitive issues related to the performance of the CEO or other C-suite staff.
- When the CEO is included, foster discussion of the relationship between the CEO and the board and discuss difficult or controversial issues that the board and CEO may not wish to share with staff.

**What is the difference between an executive session and the use of an executive committee?** While we do not propose to address the topic of executive committees further in this article, it is important to understand the difference. In sum, executive sessions typically involve the entire board, not just a subgroup, while executive committees consist of a small group within the board that is usually empowered to make certain decisions on behalf of the board between meetings. Not all non-profits make use of executive committees, and they are not without controversy, in part because they can create powerful and self-sustaining cliques within boards.

#### **How Are Non-Profit Healthcare Boards Different?**

As noted above, much of what has been written to date about executive sessions appears to be aimed at non-profit corporations generally, and educational institutions in particular. For example, a Stanford University professor recently posted an excerpt from a 2018 book on non-profit university governance by Robert A. Scott, the President Emeritus of Adelphi University, in which President Scott states that the "role and use of executive sessions are often misunderstood, even though there are legal standards to follow. For example, there

are boards that misuse the executive session by taking decisions that are inappropriate for a closed meeting."<sup>5</sup>

While assessments of the practices of educational boards can be helpful, hospitals and health systems are typically more complex than most other non-profit organizations. Healthcare boards must routinely address many thorny issues that require careful analysis, confidentiality, and trust. Hospital and health system boards must routinely deal with issues affecting quality of care and patient satisfaction; mergers, acquisitions, and strategic capital investments; medical staff recruitment, retention, and discipline; and many different kinds of regulatory compliance, potential litigation, conflicts of interest, and financial performance in a world of complex and fragmented payer sources, to name just a few. Finally, these boards require levels of complexity, expertise, and confidentiality beyond that of most other kinds of non-profits.

**W**ithout a formal agenda and guidance, a board in executive session may be discussing issues or problems they are not equipped to consider without the CEO and possibly other staff or advisors present.

#### **Basic Policies and Practices for Effective Executive Sessions**

Should a hospital or health system board make use of executive sessions, and if so, when? And which topics are suitable for executive sessions held only with board members present, without the CEO (or other staff)? While there is consensus about what constitutes a "best practice" in many areas of non-profit governance, there appears to be disagreement among governance experts about whether executive sessions are even a good idea, let alone what the best practice might be in convening them. Even those observers who endorse their use often do so with substantial caveats.

#### **Executive Sessions for Public Hospital Boards**

Executive sessions in public hospital governing boards are somewhat different than in private non-profit organizations, in that public boards typically must comply with open meeting and open record laws. These laws vary widely from state to state. While most states permit closed meetings (which can include but are not necessarily limited to executive sessions) for certain specific purposes, such as to discuss pending litigation, the exceptions in some states are extremely limited.

For additional information about the impact of state sunshine laws on public hospital boards, see Larry Gage, "Representing Public Hospitals," in *Representing Hospitals and Health Systems Handbook*, American Health Lawyers Association, 2016; p. 712.

For example, speaking from his experience with governing boards of colleges and universities, consultant and author William Mott is philosophically "very opposed" to executive sessions from which the chief executive is excluded, primarily because they "undermine the climate of trust and respect that is key to organizational effectiveness."<sup>6</sup> Mott argues that, other than issues of compensation, there is no reason to keep anything from the chief executive of a non-profit organization.

Another author, writing from the perspective of non-profit trade associations, argues that "As a non-profit, tax-exempt organization, the practices of [the] board should be relatively transparent to the members, and executive sessions throw a cloud of secrecy and suspicion on the activities of the organization...Holding executive sessions and excluding both counsel and the chief executive is a practice that strongly is recommended against."<sup>7</sup>

On the other hand, other observers agree that there are some discussions that are appropriately held just among board members. One non-profit governance expert, Ann MacFarlane, recently suggested that "there is much

5 Robert A. Scott, *How University Boards Work: A Guide for Trustees, Officers, and Leaders in Higher Education*, Johns Hopkins University Press: Baltimore, MD, 2018, excerpted in Rick Reis, "The Executive Session: A Misunderstood Dimension of Governance," Blog Post, Tomorrow's Academy, Stanford University.

6 William R. Mott, Ph.D., *Healthy Boards, Successful Schools: The Impact of Governance and Leadership on Independent and Faith-Based Schools*, December 2018.

7 S. Fellman, "Associations Should Avoid Executive Sessions," *Association Trends*, 2003, quoted in Engle and Cordes, 2014.

confusion about non-profit boards holding meetings in executive session.” In a 2020 article, MacFarlane pointed out that many boards mistakenly believe that executive sessions should be closed to outsiders, and that some boards use terms like “closed session” or “secret session” to describe executive sessions. However, she notes that Robert’s Rules of Order, which are followed by boards of many non-profit corporations, states “that board meetings are open by right only to the members of the board, and any staff or advisers whom they choose to invite.”<sup>8</sup>

**B**y disclosing certain information and creating a transparent approach to executive sessions, boards can keep a strong sense of trust among members and executive staff.

#### ***When Should an Executive Session Take Place?***

In non-profit environments, executive sessions may take place before, in the middle of, or at the end of a regular board meeting, but should take place at every board meeting. The practice of holding an executive session in conjunction with every board meeting offers the additional advantage of “diffuse[ing] the notion that executive sessions are convened only to deal with matters involving the CEO or in times of crisis.”<sup>9</sup>

#### ***Who Should Participate in Executive Sessions?***

When a board calls an executive session without the CEO, the board’s relationship with the CEO can become strained. The strain is amplified if the CEO is not aware of the session in advance and/or not informed of the discussion afterwards. This can build mistrust and can hamper the effective working relationship between board and management that is essential in a high-performing organization.

Moreover, without a formal agenda and guidance a board in executive session may be discussing issues or problems they are not equipped to consider without the CEO and possibly other staff or advisors present. While

board members may feel that they can speak more candidly without the CEO or staff present, this could also lead to ineffective discussion of a complex issue and/or poor decision making by the board.

The board’s guidelines for executive sessions should spell out the purposes for having them, when they will be considered, and who will attend. Most executive sessions should include some time when the CEO will be present and participate in the discussion and some time for the board to meet without the CEO.



#### ***What Topics Are Appropriate for Executive Sessions?***

Governance experts offer a range of specific suggestions with respect to appropriate topics for executive sessions held without the CEO (or other staff or consultants) and those which should be held with the CEO or others present.

Except in highly unusual circumstances, CEOs should be present for all executive sessions other than those that address the specific topics set out below. Moreover, even in those areas in which it may be appropriate to exclude the CEO, the board needs to take certain steps to ensure the best approach for sharing information with him or her following the closed session.

Prior to an executive session, the CEO should be presented with the agenda for the session. After the session, the CEO should also be properly debriefed on what was discussed in the meeting and the nature of the discussion. By disclosing certain information and

creating a transparent approach to executive sessions, boards can keep a strong sense of trust among members and executive staff.

To be clear, many of the topics on the lists below could also qualify for inclusion on the board’s regular meeting agenda; whether or not they require a discussion in an executive session is likely to be based on the subjective assessment that the situation in a particular area requires a higher level of confidentiality or sensitivity.

Potential topics for executive sessions without the CEO or staff may include the following:

- An annual meeting with the hospital or system’s auditor to review the organization’s financial audit and enable the auditor to provide unfiltered feedback about the hospital or system’s financial health and practices
- Conflicts between two board members, or serious criticism of a board member by another
- Legal issues involving the CEO, including investigation into concerns about the CEO, such as allegations of improper conduct and reports from management consultants about such concerns
- Evaluation of the CEO and review of the CEO’s salary and/or bonus, as well as the hospital’s overall compensation policy (provided that IRS requirements are met)
- Approving conflict-of-interest transactions with or by individual board members
- Succession planning for the CEO position

Absent an unexpected emergency or crisis directly involving the CEO, virtually every other topic that might be suitable for discussion in an executive session should include the CEO (and possibly other select employees, such as the general counsel, chief compliance officer, or chief medical officer, as needed for their expertise and familiarity with the topic at hand). Examples of such other topics include:

- Issues that “keep the CEO awake at night”
- Alleged or improper activities of staff other than the CEO
- Ongoing or pending litigation

8 Ann MacFarlane, “Executive Session in Nonprofit Board Meetings,” Jurassic Parliament, April 7, 2020.

9 BoardSource, 2007 and 2009.

- Major confidential business transactions
- Crisis management
- Responsibilities and expectations for the relationship between the board and CEO
- Quality concerns—adverse care incidents, changes in ratings by agencies or metrics that measure quality relative to other systems, etc.
- Patient satisfaction surveys and steps to improve patient satisfaction
- Employee satisfaction surveys and steps to improve employee satisfaction
- If relevant, sensitive collective bargaining issues and tactics, including preparation for possible strikes or work actions
- To discuss specific issues raised in the financial audit with or without the independent auditor present
- Future retirement plans and succession planning for C-suite management apart from the CEO
- Sensitive regulatory compliance issues<sup>10</sup>
- Major confidential strategic and capital plans, including potential mergers, acquisitions, major new service lines, or closures<sup>11</sup>
- Alleged or actual improper conduct by a board or staff member

**M**inutes of both regular board meetings and executive sessions should be succinct and provide only a summary description of the meeting, consistent with legal requirements.

#### Minutes

If the CEO and staff are not included, who should take minutes (and what kind), and how should they be preserved? As a general matter, non-profit organizations tend to keep overly detailed meeting minutes. Minutes of both regular board meetings and executive sessions should be succinct and provide only a summary description of the meeting, consistent with legal requirements. Minutes should provide the information necessary to show that an action was authorized by the board

**Additional resource:** For more information on what to cover in executive sessions at public hospitals, see “Governing in a Fishbowl: Leveraging the Time and Talents of Community Leaders on Public Hospital Boards” from The Governance Institute’s Public Focus newsletter (available at <https://bit.ly/3M4qjki>).

and that the board exercised due care in carrying out its duties. They are not intended to be a transcript of the meeting or a public document (with the exception of public hospitals). Board members would do well to bear in mind that in many circumstances, minutes are discoverable in litigation. Executive session minutes should be labeled as confidential and kept separately from board minutes in a secure location.

For the portion of an executive session where the CEO is present, he or she can draft a brief summary of the discussion and any actions taken and review it with the board chair after the meeting. For a segment that excludes the CEO, the board chair can provide a brief summary of the discussion and any actions taken. In some cases, hospitals and health systems employ a board support professional who reports directly to the board; in such cases that individual can draft the needed summary, with clear guidance about the need for brevity. In no instance should a board support professional do what one did for a number of years, which was to record every executive session without the knowledge of the board, creating what can only be called a plaintiff lawyer’s dream with respect to some of the confidential issues discussed!

Both sets of brief notes (those taken with and without the presence of the CEO) should be approved by the board at the next executive

session and filed with the board’s confidential records. The reason for the executive session should be documented briefly in the general meeting minutes.

The reasons for brevity in executive session minutes are two-fold:

1. Board members want the assurance of confidentiality in discussing personnel and other sensitive topics. Board members should feel that they are able to speak freely as well as responsibly.
2. There may be a future legal proceeding and deposition requesting the records of confidential deliberations.

#### Potential Difficulties and Ways to Prevent Them

Handled poorly or without advance planning or a clear purpose and agenda, an executive session can become a major impediment to effective non-profit governance. One governance consultant describes the following example by way of illustrating this concern: “With no warning, the board decides to go into executive session. The Executive Director is asked to leave the room. An hour or more goes by, but to the ED it seems much longer. When it’s over, the ED isn’t told what was discussed.” The author suggests that these unplanned or unpredictable sessions can be “fraught with tension,” even as they can be “a key part of effective governance.”<sup>12</sup>

In some respects, confidential executive sessions can be thought to be anathema to the transparency and duty to the community of non-profit



<sup>10</sup> Rick Marks and Regina Hopkins, “Board Basics: What a Nonprofit Board Should Know About Meeting in Executive Session,” D.C. Bar Pro Bono Center Webinar, February 15, 2017.

<sup>11</sup> Scott, 2018.

<sup>12</sup> Joan Garry, “The Problem With Executive Sessions.”

corporations. Yet many issues do require a measure of confidentiality and the opportunity for candid discussion among board members that is not always possible in the presence of staff. Unfortunately, executive sessions can be "...mistakenly used to raise concerns about the CEO or another executive, simply venting about behavior, gossiping, or addressing personal issues," according to one observer.<sup>13</sup>

**E**xecutive sessions should be planned in such a fashion as to be predictable for all parties and to preserve trust while maintaining confidentiality.

What can be done in planning and scheduling executive sessions to minimize the awkwardness?<sup>14</sup> First, the board can adopt the policy of scheduling an executive session in every board meeting—usually at the end is best, but if board meetings run long, they can be scheduled earlier in the meeting. Each executive session should have a written agenda, identifying general topics to be covered, while leaving room at the end for board members to raise new issues. However, personal agendas of individual board members should be avoided, and new issues should never be discussed or resolved in the session in which they are raised (unless they involve an emergency). If appropriate, they should be calendared for the next board meeting or executive session.

Distrust between the board and CEO is a major problem that should be avoided at all costs. "It demonstrates a lack of understanding that the CEO and board chair have different responsibilities and must work together to achieve the mission and vision of the organization," says author and consultant, William Mott. "Too often this type of executive session includes discussions about issues with which the board has limited or no information, and thus they can devolve into unproductive and inappropriate discussions or even forums to spread gossip."<sup>15</sup>

In sum, executive sessions should be planned in such a fashion as to be predictable for all parties and to preserve

According to The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems:

- 59 percent of respondents scheduled executive sessions (compared with 72 percent in 2019 and 74 percent in 2017).
- 88 percent of respondents with scheduled executive sessions said the CEO attends always or most of the time, 41 percent said clinician board members attend always or most of the time, and 41 percent said legal counsel attends always or most of the time.

The top four topics typically discussed in executive session are:



trust while maintaining confidentiality. Such sessions should be considered routine and, if the CEO is excluded, he or she should be debriefed immediately following the session except in highly unusual circumstances.

### Evaluating and Improving Executive Sessions

It is important for boards to keep in mind that there are many positive reasons for holding an executive session to permit candid discussions about issues involving board operations and the organization as a whole. To minimize awkwardness, the board should consider making executive sessions a routine component of board meetings, instead of calling them for a particular purpose. This should enable the CEO and staff to rest a bit more easily, while providing board members with a predictable forum to converse, exchange ideas, and express concerns. Executive sessions should be focused only on those topics that require a measure of confidentiality—they are not intended to be alternative board meetings for conducting regular board business.

The board should consider adopting board policies or even bylaws amendments that create a routine process for calling and conducting executive sessions, including a list of topics that are considered necessary or acceptable for consideration in such sessions. All executive sessions should be held for their determined purpose only. After that purpose has been met, the session should end.

If the chief executive is not in attendance, the board chair should inform the chief executive soon after of any specific conclusions or recommendations that surfaced during the meeting.

It is advisable to keep a written record of all executive session proceedings. While detailed minutes are often not necessary, the record should include the date, time, and place of the meeting, names of those people present, any actions taken, and any abstentions from voting if voting took place. These minutes are confidential and should be distributed to only those who were present in the session.

Finally, the ability to improve the effectiveness of executive sessions—and of governance generally—may also

<sup>13</sup> "Proper Planning and Execution for Executive Sessions," Govenda, 2021.

<sup>14</sup> Marks and Hopkins, 2017.

<sup>15</sup> Mott, 2018.

depend on paying attention to your board's theory of governance. While this is not a one-size-fits-all approach, there are clearly best practices in non-profit governance generally that, if adopted, could improve the board's ability to benefit from executive sessions.

Engle and Cordes postulate that the concept of an executive session differs from board to board, based on the type of governance, and suggest that there are three basic types:

- A "controlling board": The chief executive serves as the agent of the board, which delegates work to and closely monitors the actions of the agent.
- A "collaborative board": There is a solid working relationship between the board and the chief executive, and the board assumes that, in general, managers can be trusted to be good stewards. That trust, cohesiveness, and openness are core concepts and the board and management share a unified sense of direction, command, and control.
- A "passive board": Governance is dominated by management and is a "creature of the CEO," even though it is the formal governing power, and in which the board is typically little more than a legal fiction.<sup>16</sup>

We have encountered examples of each of these boards in our work with

non-profit hospitals and health systems. We would also suggest that there is another way to categorize the governance approach of hospital boards: as "constituency-based boards" with many *ex-officio* members appointed to represent various interests; "professional/expert boards," which are composed of individuals selected to bring a range of skills and experience, as well as a diversity of backgrounds, to the table; and "honorific boards," whose members are appointed primarily because of their social stature in the community and/or their ability to engage in fundraising activities for the hospital or system.

**B**oard self-evaluation is itself a governance best practice that can benefit from the effective use of executive sessions to encourage confidentiality and candor.

### Concluding Thoughts

When you combine these governance theories in some manner, it is possible to see that there are likely to be substantially different approaches to executive sessions. To illustrate, a constituency-based controlling board is more likely to make extensive use of executive sessions without the CEO or

other staff. A passive, honorific board, on the other hand, may have little need for executive sessions at all, except perhaps to conduct an annual review of the CEO.

As your board considers the employment and design of executive sessions, it is very important to be mindful of how your organization views the role of governance and how you want your board to function.

It is also important for a board to routinely evaluate how well the board functions. Such an evaluation should extend to both the board as a whole and its components (committees) and individual members. Board self-evaluation is itself a governance best practice that can benefit from the effective use of executive sessions to encourage confidentiality and candor. The Governance Institute advocates a philosophical framework known as Intentional Governance, with the main idea being that boards that regularly look inward, assess how they are doing as a board, and put in place mechanisms for continuous improvement are more effective boards. They honor process and policy while ensuring that they are never satisfied with the status quo. They are more effective in overseeing their organizations and holding management accountable for achieving goals. Intentional boards also tend to have open, transparent, and trusting relationships with their CEO and senior management. The board chair does not overstep, and encourages all board members to voice their concerns, regardless of how sensitive the issue may be. Establishing the best practices and processes for executive sessions demonstrated in this article is a core component of Intentional Governance and has the potential to make a significant positive impact on your board's engagement, dynamics, and culture.

*The Governance Institute thanks Larry Gage, Esq., Senior Counsel, Alston & Bird LLP, and Senior Advisor, Alvarez & Marsal, and Lawrence Prybil, Ph.D., LFACHE, Norton Professor in Healthcare Leadership (Ret), University of Kentucky College of Public Health, for contributing this article. They can be reached at [larry.gage@alston.com](mailto:larry.gage@alston.com) and [larryprybil@gmail.com](mailto:larryprybil@gmail.com).*



<sup>16</sup> Engle and Cordes, 2014.



this. Every initiative we start begins with the councils—what they think, how they can inform the design and implementation, and how we will communicate it to the public. With SDOHs, we did a lot of qualitative research with patients to learn how to explain why we are asking personal questions such as if a patient feels safe at home or can afford their medications. Helping patients understand why we are asking, what we are going to do with the information, and what kinds of support they will be receiving, is a game changer.

**TGI: How do you gather this information from people in the community who aren't yet patients?**

**SEL:** We have deep relationships with certain communities where we are the dominant provider. In Chelsea, which is a small community with the highest number of patients with chronic conditions across our state, we created Healthy Chelsea. It is a community group that includes the leadership of the MGB Chelsea Community Health Center, the police chief, the school board chair, the mayor, the town administrator, and the head of probation

services, among many others. We share our SDOH data with them, so they know where they have housing or education challenges. We have similar relationships like this in other communities. Even though we don't provide care to everyone, the work those organizations do affects everyone who lives there.

In Chelsea they learned that there was a high incidence of trauma in children who had witnessed any kind of violence. When an incident occurs, a social worker on call is paged, who comes to meet with the children involved along with a police officer who is specially trained. The intent is to provide emotional support and to minimize people being afraid of the police. Young children who are part of this program get to know the police officer and social worker over time. Many of these children grow up and decide they want to be a police officer or doctor because of the support they received through this program.

**TGI: What is your post-COVID outlook—where do we need to go with Human Understanding?**

**SEL:** Everyone is dealing with massive staff shortages and burnout. Human Understanding is critically important to moving our organizations forward. At MGB, we are engaging with the primary care practices that have been hit hardest by COVID, through a focused series of events culminating in a retreat. The purpose is to help them think positively about the future. We interview staff and doctors and ask, what are the strengths of your practice, and what are the challenges? What is your vision for your practice in the future? We use that to create a draft vision for the practice that we share during the retreat.

We start the retreat with a "why" exercise: why are they there, why are they working in healthcare, what does it mean to them, why is it important, and why are they working in this practice? They discuss these questions for an hour in a small group of people they don't normally work with. This helps them get to know each other better, which improves communication and teamwork. It also shows the clinical staff how committed all staff are to making a difference for their patients. Then we do an "I Care" training: communication, advocacy,

**//** Boards don't always understand the connection between how we take care of our staff and how we take care of our patients. It's a critical connection that fosters deep Human Understanding and successful healthcare organizations."

—Susan Edgman-Levitan

respect, and empathy. We use real NRC Health experience data and comments to show where they are doing well and where they have challenges. We also ask them to define what these behaviors look like—what does good communication, advocacy, respect, and empathy look like to you? We take them out of their comfort zone, so they look at things from a different lens. They come up with work plans and we help with process improvement support so they can develop and implement new workflows.

**TGI: What do you feel are the important takeaways for boards from this conversation?**

**SEL:** Boards need to focus on defining the values of the organization and how everyone will be held accountable to those values. Their focus on the patient's experience, clinical quality, and safety is as critical as their focus on financial outcomes. They also need to prioritize the resources to make sure these things can happen. They should be vigilant about promoting high-quality care and patient experiences backed up by reliable evidence as opposed to assuming that empty marketing campaigns will be enough.

They also can help by supporting regular evaluations of employee engagement and culture surveys—there is evidence that those that score well on culture surveys perform well on patient experience and outcome measures. Boards don't always understand the connection between how we take care of our staff and how we take care of our patients. It's a critical connection that fosters deep Human Understanding and successful healthcare organizations.

## Compassion in Action...

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metastatic cancer did not have those ICD-10 codes.

- Included people over age 75 with a prior admission in the past year who were not captured by these other criteria.

Over half of patients in our 516-bed hospital were identified as having a serious illness on any given day. We are now working on processes to determine what their palliative care needs are and how best to address those needs, including through palliative care consultation. This approach will undoubtedly find many more patients who need palliative care than are currently receiving it or than our teams can see. Nonetheless, this systematic, population-based, proactive approach will allow us to allocate our resources to those patients that need them most and decide whether to expand our palliative care capacity.

Short of this EMR-based screening approach, a hospital can focus the work of a palliative care team to have the greatest impact. Analysis of the Palliative Care Quality Network (PCQN), a large, national database with patient-level outcomes collected by palliative care teams, found that one quarter of patients referred for palliative care consultation have moderate to severe pain, and 40 percent of those patients were not referred for pain.<sup>6</sup> Overall, the PCQN data shows that palliative care teams are able to improve pain in 80 percent of patients with moderate to severe pain and reduce their hospital length of stay by two days. Furthermore, when the palliative care team sees the patient on hospital day one, pain is more likely to improve and length of stay is shorter by an average of 1.5 days. Taken together, these findings show that seeing patients on hospital day one is associated with better quality (improved pain) and reduced utilization (shorter length of stay). Instituting protocols to identify patients with serious illness and pain in the emergency department and embedding palliative care teams with teams that care for many sick patients—like the ICU or advanced lung service—can help get palliative care teams engaged sooner and achieve better outcomes.



The best data for the benefits of specialty palliative care are in the outpatient setting. The potential need for specialty palliative care in the outpatient setting is huge and identifying the neediest patients is critical to maximize impact. Palliative care teams can apply a population-based approach by targeting clinics enriched for people with serious illness. For example, at UCSF we have close collaborations with the ALS clinic, interstitial lung disease clinic,<sup>7</sup> hepatology clinic, and Parkinson's disease clinic. These practices care for patients that, by definition, have a life-limiting serious illness. Working with the clinicians in those practices has fostered a close partnership leading to more and earlier referrals to palliative care. This collaboration also supports mutual education that improves the care of patients. In our palliative care clinic, we follow patients for a median of seven months and up to three years. We found reductions in hospitalizations and hospital days in the six months after referral compared to the six months before. We also refer 62 percent of patients to hospice, compared to 45 percent of Americans that die overall, and they have a longer median length of stay—30 days compared to a national median of 18 days. Interestingly, the EMR-based screening algorithm for serious illness that we implemented in a primary care practice has not proven to be very effective.

Home-based palliative care is another important service in a comprehensive approach to providing high-quality care for people with serious illness. Typically, these services are led by nurses and target people with advanced serious illness like heart failure, COPD, cancer, and dementia. For these services, EMR- and

claims-based algorithms are effective in identifying patients likely to benefit. Key features include 24/7 availability, home visits at least monthly, and support for the patient and family. These programs are associated with high satisfaction, lower utilization, and longer hospice use.<sup>8</sup>

At a lecture, the famous anthropologist Margaret Mead mused about the earliest sign of civilization. She reflected that many people say it's a shard of pottery, a tool, or an idol. To her, the earliest sign of civilization is a 15,000-year-old healed human femur. She explained that a healed femur required someone to take care of you—to provide food and shelter and keep you safe for many weeks. No one can survive such a devastating injury on their own. Only in a group where individuals look after each other and show caring and compassion can the injured individual survive to heal the femur fracture. The caring and compassion that makes that healing possible is the earliest sign of civilization.

In the face of suffering and illness, we in healthcare are among the torchbearers of caring and compassion. Over the next 25 years, the number of people in the U.S. with serious illness will more than double. This growth is good news for all of us who will benefit from this increased longevity. At the same time, this change will pose a challenge to our healthcare system charged with caring for this growing population of people with high healthcare needs. As a nation and as leaders in healthcare we must embrace this challenge and opportunity. Taking a population approach to implementing palliative care is one way to demonstrate that compassion while improving care for our patients and creating the system of care we will want for our families, friends, communities, and ourselves.

*The Governance Institute thanks Steven Pantilat, M.D., Professor of Medicine and Chief of the Division of Palliative Medicine at the University of California, San Francisco, for contributing this article. He can be reached at [steve.pantilat@ucsf.edu](mailto:steve.pantilat@ucsf.edu).*

6 Steven Pantilat, et al., "Identifying Opportunities to Improve Pain Among Patients with Serious Illness," *Journal of Pain and Symptom Management*, 2018.

7 Steven Pantilat, et al., "Better Together: A Mixed-Methods Study of Palliative Care Co-Management for Patients with Interstitial Lung Disease," *Journal of Palliative Medicine*, June 11, 2021.

8 Dana Lustbader, et al., "The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization," *Journal of Palliative Medicine*, January 2017.

## Building Strength Through Innovative Partnerships

*continued from page 3*

testing site on the Mercy Fitzgerald campus. The Pennsylvania Department of Health soon joined our collaborative response effort by providing additional funding and support, before the Federal Emergency Management Agency also got involved. Together, we were able to meet the urgent demand for COVID-19 testing in Delaware County.

### Non-Profit Partnerships

Luckily, we are not alone in our dedication to community support. Mercy Fitzgerald collaborates with likeminded non-profit organizations in our region to support the underserved. In partnership with Broad Street Ministry, a non-profit organization that serves people experiencing homelessness throughout Philadelphia, we operate a “community hygiene truck.” The hygiene truck, which originally launched in October 2021 as part of a program to distribute personal care products to individuals experiencing poverty, was recently upgraded to feature built-in hygiene and

telehealth components. The customized box truck is now enabled to offer a hand-washing station and provide primary medical care to individuals struggling with homelessness and chronic health conditions. The mobile unit still also distributes free personal care items such as soap, deodorant, and toothpaste.

### Community Partnerships

We also partner directly with our community members, who have shown incredible generosity in support of their neighbors. In December 2021, the Heart of Mercy Committee at Mercy Fitzgerald Hospital—a group of engaged colleagues who actively work to enhance the culture of the organization through three key service pillars: service to our patients, service to ourselves, and service to our communities—organized a book drive to benefit Delaware County. Over 3,000 books were collected during the drive, including 500 books donated by members of our community. The collected books were distributed to

local schools, shelters, and other community programs.

Such partnerships do not materialize on their own; they require extensive time, attention, and funding to develop and launch. But as my colleagues, the members of our board, and I can attest, their results have been worth far more than the effort required to build them.

It’s up to individual hospital boards and leaders to find a better way forward in meeting the needs of our underserved community members. Through innovative partnerships, we can overcome even the most difficult industry challenges and keep our focus on the needs of every patient, regardless of their place in our society. Isn’t that our true calling as healthcare providers?

*The Governance Institute thanks Chris Cullom, FACHE, President, Mercy Fitzgerald Hospital, Trinity Health Mid-Atlantic, for contributing this article. He can be reached at [christopher.cullom@trinity-health.org](mailto:christopher.cullom@trinity-health.org).*

## Five Steps to Improve Board Effectiveness...

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### Board to-dos:

- Evaluate board, committee, and individual performance regularly; provide feedback and address issues openly with appropriate action plans to follow up.
- Consider if board members need to be added or replaced. For example:
  - » Could the board benefit by having someone from outside of the area to bring fresh perspectives, viewpoints, and skills?
  - » Can and should the board more fully reflect elements of diversity regarding demographics, socioeconomic status, ethnicity, gender, experience, and other characteristics in the community it serves?

### 5. Do the “Right” Board Work

Assess if the board is consistently focusing on governance, not operations. Doing the “right” work means that time spent in board and committee meetings focuses on analysis, deliberations, and decisions that deliver leveraged results. Ensure that the board is moving forward with fulfilling the organization’s mission in demonstrable ways, measured by monitoring progress implementing and achieving the goals, strategies, and key performance indicators in the strategic plan.

### Board to-dos:

- Consider if the board is effective with its time, as demonstrated by results. Is there a consistent pattern of focused data analysis, robust deliberation, timely decisions, and effective implementation?
- Regularly ask, does the organization have the right strategic plan? If so, is it being implemented effectively?
- Ensure the board is spending 50 percent of its time (or more) on strategic issues versus hearing reports.
- Periodically assess what percent of maximum potential contribution the board is providing to the hospital or health system. Discuss what could be done differently to significantly increase the value that the board provides.

### Board Effectiveness and Continuous Improvement

For the past two years, board education and development opportunities have dwindled significantly. Many boards have added new members, as well as transitioned experienced members off. Board orientation, mentoring, and education has been more difficult to effectively achieve. Make the effort to

catch up with these essential activities either in-house or through external means, now that many of the large industry associations are holding in-person conferences. Attending these events (even if virtually) will provide multiple returns.

The pandemic experience has shown that very little in healthcare can or will remain static, including how governing boards perform their essential functions as fiduciary stewards and guardians of their organization’s mission and vision. Be willing to talk about new ideas boldly, and traditional things differently. Take proactive steps to ensure that your board continuously provides the maximum possible contribution to the hospital or health system to ensure its sustainability and success into the future.

*The Governance Institute thanks Guy M. Masters, M.P.A., President of Masters Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at [guymasters11@gmail.com](mailto:guymasters11@gmail.com) or (818) 416-2166 and [www.mastershealthcareconsulting.com](http://www.mastershealthcareconsulting.com).*

# Five Steps to Improve Board Effectiveness: Now Is the Time to Act

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**A**n important insight coming out of COVID-19 is that improving board governance must be a top priority that demands intentional and focused attention, renewed energy, and willingness to change. Complacency and status quo are not acceptable options for boards that expect their hospital or health system to be successful in the coming months and years.

This article provides five specific steps to accelerate (or jump-start) a proactive energized approach to performance improvement and governance effectiveness.

## 1. Regroup, Refocus, and Re-engage

Boards should hold an in-person retreat as soon as possible (and safe). Most boards cancelled or postponed in-person retreats during the pandemic resulting in lost opportunities to plan, network, and experience the value of face-to-face deliberations. After two years of virtual meetings, many boards report that engagement is down and they have lost something culturally.

**Board to-dos:** It is time to reconnect if you haven't done so already. Retreat topics can include:

- Industry trends and their impact on the organization's future success
- Key lessons learned from the pandemic experience (financial, operations, clinical, workforce, strategic, and culture)
- Potential beneficial partnerships, alliances, or other affiliations that should be pursued with greater attention and intensity (think in terms of service line affiliations, IT ventures, branding, clinical networks, payer opportunities, physician alliances, ventures that create economies of scale, and other non-merger options)
- Geographic footprint and virtual outreach strategies (ambulatory, free-standing, technology, other outpatient, and diagnostic opportunities)
- Envisioning the future of the organization five to seven years forward using exercises such as Vision-by-Design, scenario planning, "what's the worst/best that could happen," and other activities that stretch strategic thinking possibilities

## 2. Update, Recalibrate, and Accelerate the Strategic Plan

Review everything that has been accomplished; acknowledge and celebrate it, then assertively move ahead toward the future. Get away from operations and make the document a true strategic roadmap.

**Board to-dos:**

- Review (and update if necessary) the mission, vision, and values.
- Focus on forward-looking goals and visionary *strategic* priorities.
- Test the degree of your strategic plan's content by marking each strategy listed under a goal or pillar with an "S" if it is truly strategic in nature, an "O" if it is operationally focused, or a "B" if it is both strategic and operational in nature. Divide the number of "S" markings by the total number of strategies listed for all the goals, and this will show how strategic the plan really is.
- Get broad-based input on strategies; set high (realistic) expectations.

## 3. Assess Board Structure

Ensure that the right board structure is in place (streamlined, well-functioning, focused, and right-sized), with the optimal number of members, reasonable meeting frequency and cadence, highly effective and trusted committees, clear and specific board goals, and high standards of performance. Take a "zero-based-budget" approach to examining board committees. Is there a committee (or two) that should sunset? Examine committee annual goals with a fresh perspective; set at least one stretch goal for each committee to pursue in harmony with refreshed annual board goals and the organization's strategic plan.

**Board to-dos:**

- Ask, does the board structure facilitate effective governance?
- Review past board self-assessment survey results and follow-up action plans; schedule a post-pandemic

## Key Board Takeaways

- Leadership-by-example is the best way to effect change, including being open to constructive criticism, willing to entertain new ideas, and demonstrating accountability for results.
- Periodically engage the CEO in an open and frank discussion about guidelines and parameters distinguishing governance from management. Anticipate and prospectively prevent "drift" from occurring from one side of responsibility into the other.
- Reestablish the pattern of conducting regular board self-assessments, including assessments of individual board members; post-pandemic is a great time to re-engage in the process and then create action plans based on the results.
- Follow Governance Institute recommended practices such as assessing the organization's bylaws and structures at least every three years, reviewing the mission statement annually to ensure its ongoing appropriateness, and ensuring all directors complete a conflict-of-interest disclosure statement annually.
- Take time to ask: What governance best practices would help the board become *extraordinary*?

self-assessment if one has not been done in two or more years.

- Review board leadership development, ongoing education, and succession planning practices.
- Assess board meeting management (e.g., quality of strategic discussions vs. tactic-focused dialog, board goals, use of consent agendas, use of board portal, annual calendar, and meeting effectiveness measures).

## 4. Review Board Member Competencies and Contributions

Take a renewed look at the board's overall make-up in terms of collective and individual contributions. Do board members engage in generative discussions? Are they willing to constructively challenge the status quo? Update the board competency matrix to reflect anticipated future needs (and gaps). Examine if the board is made up of the right members with the highest caliber of needed competencies, including members who are mission-focused, low drama, high energy, diverse, inclusive, and have a passion for the mission and results.

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